



Health Resource Facility
for Australia's Aid Program

Timor-Leste Health Program

Gender analysis

Final

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Contents

Executive Summary	3
1. Introduction	4
2. Methodology.....	5
3. Limitations.....	5
4. Situational analysis.....	6
4.1 Institutional context.....	6
4.2 Culture, tradition and modern history	7
4.3 Violence against women.....	8
4.4 Disability	9
4.5 Education	9
4.6 Political life and participation in decision making.....	9
4.7 Economic empowerment	10
4.8 Maternal and child health.....	10
4.9 Nutritional status.....	11
5. Gender issues in the health sector and their implications for program outcomes	11
5.1 Health service delivery.....	12
5.2 Infrastructure, supplies, equipment and transport	12
5.3 Health workers.....	12
5.4 Health financing.....	13
5.5 Health information	13
5.6 Leadership and governance	13
5.7 Community mobilisation.....	14
5.8 Multi-sectoral dynamics	14
6. Recommendations	15
6.1 'First tier' recommendations	15
6.2 'Second tier' recommendations	16
6.3 Aligning the program to gender-related concerns in the Country Situational Analysis and the Ending Violence Against Women (EVAW) program	
19	
7. Conclusion	20
Annex 1: Institutional context	21
Annex 2: Maternal health	24
Annex 3: External influences.....	26
Annex 4: Possible gender equality indicators for investing in people	28
Annex 5: Methodology	36

Acronyms

BESIK	Be'e Saneamentu no Ijiene iha Komunidade/ Timor-Leste Rural Water Supply and Sanitation Program
CEDAW	Convention on the Elimination of all Discrimination Against Women
CSO	Civil society organisation
DFAT	Department of Foreign Affairs and Trade
DHS	Demographic and Health Survey
DPCM	Development Policy Coordination Mechanism
FRETILIN	The Revolutionary Front for an Independent East Timor / Frente Revolucionária de Timor-Leste Independente
GAU	Gender Affairs Unit
GFP	Gender Focal Point
GoTL	Government of Timor-Leste
GRB	Gender Responsive Budgeting
GWG	Gender Working Group
HMIS	Health Management Information System
MDG	Millennium Development Goal
MoH	Ministry of Health
NGO	Non-governmental organisation
OPE	Office of Promotion of Equality
OPMT	Popular Organisation of Timorese Women
REDE FETO	Timor-Leste's Women's Network
RMNCH	Reproductive, maternal, neonatal and child health
RSF	Family Registration System
SEPI	Secretary of State for the Promotion of Equality
STI	Sexually transmitted infection
TB	Tuberculosis
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Fund for Women
UNMIT	United Nations Mission in Timor-Leste
UNTAET	United Nations Transitional Authority in East Timor
WASH	Water, sanitation and hygiene
WFP	World Food Programme

Executive Summary

This gender analysis aims to inform Australia's new health design in Timor-Leste by establishing: key gender equality issues; the main supply-side and demand-side barriers to better health for women and their children; and the implications of these issues for progress against the outcomes proposed in the design of the new program.

Timor-Leste's commitments to gender equality are not yet reflected in the health of its people. Gender-related barriers that affect care-giving and care-seeking for women and their children are found in each of the health system building blocks as well as in other sectors. Lack of reliable transport is an obstacle to both delivery and use of services and the cost of transport to and from hospital can also deter usage, even in obstetric emergencies. Blood transfusion services are not available for obstetric emergencies and vital commodities are often in short supply.

Doctors and nurses lack training in obstetrics. There are not enough midwives and many lack training in emergency obstetrics. Lack of suitable accommodation for midwives, single female doctors and married couple doctors make remote postings difficult to fill. Women are discouraged from using health services by health worker anger and blame, and health workers in turn are disheartened by users' lack of awareness of the importance of prevention and early intervention. Some customs and beliefs surrounding birth and neonatal care are incompatible with modern good practices.

Women do not participate equitably in health sector leadership and governance, gender-responsive budgeting is not yet the norm in the Ministry of Health and routine health information is insufficiently sex-disaggregated. For these reasons neither planning nor resource allocation is geared to improving gender equality in health. Knowledge of the relationship between violence against women and key health issues and disability and access to health services is patchy and more research is needed.

Using a highly flexible 'learning by doing' approach involving a sequence of 'package cycles', partners in the new health program can reduce gender inequality in health by: (i) prioritising cycles that will help reduce maternal deaths and/or overcome gender-based barriers to care-giving and care-seeking in the choice of bottlenecks to be tackled; and (ii) ensuring there are effective incentives for women as well as men to participate as both users and 'implementers'; and (iii) monitoring and evaluating each cycle for gender-specific effects. The first package cycle, which focuses on health transport, should be used as a pathfinder for (iii).

In addition to these 'first tier' recommendations, the new program could – subject to program partners' agreement on choice of subsequent package cycles support the Ministry of Health to develop and implement a gender equality strategy for the sector. Other 'second tier' recommendations for improving gender equality in health concern service delivery, health workers, health financing, health information and community mobilisation.

The report concludes by recommending ways to align the health program with the Ending Violence Against Women program, which is also funded by Australia.

1. Introduction

This analysis was commissioned to inform the design of Australia's new Timor-Leste Health Program, which is due to begin in 2014. Just as investing in health will help create a more productive population as part of the national development effort, so addressing gender issues in health will help to ensure that the entire Timorese population can contribute optimally to the country's development.

For the sake of brevity the term 'program' will be used throughout the document to mean the program partnership between the Timor-Leste Ministry of Health (MoH) and Australia, which will also include multilateral development partners and civil society organisations as required for each 'package cycle'.

The goal of the new health program is to contribute to lower death rates and better health amongst all Timorese mothers and children. The end-of-program outcomes focus on strengthened availability and quality of health services and improved health-related behaviours. Intermediate outcomes relate to a series of 'package cycles' in which (i) policy makers prioritise constraints to services and behaviour change and incentivise their resolution and (ii) implementers and users collaboratively and iteratively resolve priority constraints. Gender and disability cut across the program.

The Australian Department of Foreign Affairs and Trade (DFAT) Timor-Leste Health Delivery Strategy proposes that equitably reducing child and maternal mortality will depend on a range of factors including women and girls becoming better-educated; communities and households increasingly practicing behaviours that are conducive to better health; and women and children, especially the most vulnerable, increasingly using high quality reproductive, maternal, neonatal and child health (RMNCH) services. For the latter two, international best practice indicates that maximum impact is achieved through an integrated 'continuum of care' that begins with family planning and antenatal care and goes on to include care at delivery, postnatal care and essential newborn care, followed by care for infants and children. This continuum of care must link communities (where the most basic care, such as feeding and hygiene, takes place), primary health care facilities (particularly immunisation) and hospitals (to deal with life-threatening events involving mothers and newborns).

While demand- and supply-side barriers obstruct access to care for both men and women, deeply entrenched gender inequalities have a significant impact on a woman's overall health status, as well as the health of her children. Even when services are available, women's low status may continue to undermine their access to care and their ability to adopt behaviours that promote better health. Hence it is important to mitigate not only the supply-side failures that contribute to maternal and child mortality and morbidity, but also the combination of social and economic factors in the wider environment that drive gender inequality in health.

In other words, it is important to distinguish between women's practical needs and their strategic needs. The practical needs include nutritious food, clothing, housing, access to medical services and basic education; if all of these needs are met, women's health status will certainly improve. However, women will remain disadvantaged unless their strategic needs are also addressed. These include education, livelihoods, incomes, participation in politics at all levels, assistance with child care, freedom from violence and the right to control their own fertility.¹

¹ Carolyn Moser, *Gender Planning and Development Theory, Practice and Training*, 1993, Routledge, London

Gender equality cannot be achieved without restructuring power relations – within families and within societies - so that both women and men have a voice in the functioning and development of their community and country, that both are able to benefit from the new opportunities that development brings, that both have access to the resources needed to be productive members of society and that both share in a higher level of well-being. This is a long-term process involving all sectors at all levels.

The health program design emphasises identifying windows of opportunity, achieving tangible political payoffs, building on what is already in place, acting as facilitators and being adaptive and responsive. This fits well with recent thinking, including the New Deal for Engagement in Fragile States.² The program will undertake, in partnership, interventions that produce politically valued results in the short term as entry points for locally owned, longer-term transformational change. This approach is also well-suited to advancing gender equality.

This gender assessment presents (Section 4) an overarching situational analysis of gender in Timor-Leste and relates these broad concerns to women's health. The analysis then considers (Section 5) how gender issues may constrain progress against program outcomes. Section 6 provides recommendations on ways of working, on specific barriers outlined in Section 5, and on aligning the program with the country situation analysis and the Ending Violence Against Women (EVAW) program.

2. Methodology

See Annex 5.

3. Limitations

This gender analysis relates to the design for a flexible program to support Government-led implementation of Timor-Leste's national health plans in a way that progressively strengthens national systems. The program will respond to opportunities as they emerge, iteratively define activities to resolve bottlenecks that constrain service delivery and improvements in health-related behaviours, and use timely feedback to adjust plans and implementation quickly.

In view of this, there are few specific activities at this stage for the gender analysis to focus on so, the recommendations refer primarily to principles and ways of working and to the health system building blocks.

For the same reason it is not possible to recommend monitoring and evaluation (M&E) indicators for the program until the thematic focus of the program's intermediate outcomes are specified. Annex 4, however, provides a menu of possible indicators from DFAT tools and guidelines. Some of these could be discussed with program partners for inclusion in the M&E framework.

² The New Deal is a partnership between fragile states and development partners that aims to improve engagement in policy and programming.

4. Situational analysis

4.1 Institutional context

Timor-Leste currently chairs the g7+, group of fragile states, which aims to share lessons and improve the way that international partners engage in conflict or post conflict countries. The International Dialogue for Peacebuilding and Statebuilding, which works in close partnership with the g7+, concerns ways of working in fragile states. The International Dialogue recognises "...that constructive state-society relations and the empowerment of women, youth and marginalized groups, as key actors for peace, are at the heart of successful peacebuilding and statebuilding. They are essential to deliver the 'New Deal' ... We will ensure that specific support is targeted to promote youth and women's participation in political dialogue and leadership initiatives."³

The New Deal has developed a set of country level indicators based on submissions by a number of countries, including Timor-Leste. For the two indicators that apply to service delivery (distribution of services and public satisfaction with service delivery), disaggregation by gender, region and social group is recommended.

Provisions for gender equality in the Timor-Leste Constitution include: the same rights and duties in all areas of family, political, economic, social and cultural life; the promotion of equality in the exercise of civil and political rights and non-discrimination on the basis of gender for access to political positions; that special protection should be afforded to women before and after birth; and the right to paid maternity leave.

Timor-Leste has signed and ratified all the major gender-related conventions or international instruments, including the Convention on the Elimination of all Discrimination Against Women (CEDAW). The principle of equality is also reflected in the Law against Domestic Violence, the Labour Code and the Electoral Law, which sets targets for women's representation in Parliament.

In 2002, the Office for the Promotion of Equality (OPE) was established within the Prime Minister's Office, to advise on mainstreaming gender throughout the government. In 2008, OPE was replaced by the more substantial Secretary of State for the Promotion of Equality (SEPI) with responsibility for creating, coordinating and assessing gender equality promotion policies across government.

The Program of the Fifth Constitutional Government of Timor-Leste (GoTL) 2012-2017 articulates strong commitments to social inclusion. It refers to the Gender Integrated Approach, which is part of the effort to achieve fair representation of women and men in government agencies.

The Program of the Fifth Constitutional Government of Timor-Leste declares that the Government will enhance its commitment to gender equality in all spheres of life; that gender equality must be a central consideration of all Government programs and decision making; and that empowerment of women depends on government leading collaboration between the organs of sovereignty, civil society, religious organisations, non governmental organisations (NGOs) and the community. It states that the Government will continue its endeavours to ensure implementation of the Beijing Platform for Action and CEDAW, alleviating women's poverty, addressing women's health and education discrimination and eradicating domestic violence; and that gender equality will become a cornerstone issue because addressing gender equality

³ International Dialogue on Peacebuilding and Statebuilding (2011) A new deal for engagement in fragile states

is a whole of government task that requires collaboration and cohesion between the security, health and education sectors, the judicial sector and other ministries and agencies. The Government will ensure that gender equality will be encompassed into initiatives, meetings and planning across government administration.

The Gender Integrated Approach has improved the gender balance in all government agencies dedicated to national development. However, the Government intends to intensify its focus on gender in key ministries - including the Ministry of Health – through the Secretary of State for the Promotion of Equality (SEPI), which will continue to promote regular meetings between the gender working group at the national and district levels and in each State agency.

This requirement for a whole-of-government approach, the Gender Integrated Approach, and the role of SEPI are highly relevant to the goals and operation of the new health program.

For a more complete description of the institutional setting for gender equality see Annex 1.

Despite GoTL's commitment to gender equality, the realities of life for most Timorese women mean that they are much more likely to die in childbirth than women in any other country in the region. They are much less likely to be literate than men, and have less chance of completing secondary education. The following sections provide a brief overview of the social, economic and political factors that continue to constrain women's ability to improve their health, and, in many cases, the health of their children.

4.2 Culture, tradition and modern history

Timorese academics have argued that Timorese culture considers men and women as operating in different realms within a dualistic concept in which feminine ritual power is protected by the 'outside' male political power. The *lulik* or spirit world regulates relationships and social contracts.⁴

Within customary practice, gender relations are mediated through marriage, which is regarded as a union between two families rather than two individuals. Rural girls are married at puberty when they are sexually mature, while boys marry when they are economically productive. Marriage involves protracted negotiations between the families to determine the bride price or *barlaque*. This is an unequal exchange of goods between families of the bride and groom with the groom providing livestock and the bride's family *tais* (traditional woven shawls) and other gifts of symbolic significance but lower monetary value. This has been interpreted as giving a husband the right to do as he likes with his wife.⁵

Commonly, a young woman will be married to a man seven to ten years older than her. In a culture where age is a source of status, this difference in age further reinforces the superior status of the husband. Married men start to participate as decision makers as fully responsible members of society, with women as wives and mothers responsible only for the household and domestic sphere.⁶

Women's roles and status are not only influenced by tradition but also by relatively recent external influences such as: Portuguese colonisation and Catholic missions,

⁴ John Trindale, *Lulik: The Core of Timorese Values*, Communicating new research on Timor-Leste, Conference Presentation, Dili 30 June 2011

⁵ Patsy Thatcher, *The Role of Women in East Timor Society*, Monash University, Dept of Anthropology, 1988

⁶ Ann Wigglesworth, *Dreaming of a Different Life: Steps Towards Democracy and Equality in Timor-Leste, Ellipsis*, 10 (2012) 35-53, 2012

which reinforced women's domestic roles and subjugation to male authority; the violent and militarised Indonesian occupation, which radically shifted women's roles; and the progressive international norms and gender policies of the UN administration and international agencies since 1999⁷ (see Annex 3 for more details).

4.3 Violence against women

Violence against women affects their physical and mental, sexual and reproductive health. Consequences include pain, limited mobility, acquired disabilities, poor overall health, and sometimes death. Sexual violence can lead to unintended pregnancies, induced abortions, gynaecological problems and sexually transmitted diseases. The social and economic costs of violence against women include reduced ability to care for their children and to work. In some cases it can force them into low paid or insecure work that increases their vulnerability to exploitation and abuse. Direct economic costs include those associated with legal, medical and refuge services and the costs of prosecution and incarceration of perpetrators.

The following are findings from a secondary analysis of the 2009-10 National Demographic and Health Survey (DHS):

Over one in three Timorese women experience physical abuse, particularly those who are married. Among married women who have experienced violence, over 80 per cent have been abused by a partner or ex-partner. Over three per cent of women experience sexual abuse, with four per cent of married women experiencing sexual abuse. In total, 45 per cent of ever-married women have experienced either physical (34 per cent) or sexual or emotional violence (11 per cent). Women in rural areas are less likely to experience violence than those in urban areas.

Women experiencing violence are more likely to seek help from friends and family than from the police, religious leaders or health care professionals, none of whom receive much training in assisting or protecting such women .

Timorese women experiencing violence are more likely to be using traditional methods of contraception, rather than modern methods, leaving them more likely to fall pregnant with unwanted pregnancies than those using modern methods. They are more likely to terminate a pregnancy and since abortion is stigmatised as well as illegal and likely to be unsafe, such women risk serious consequences.⁸

Four per cent of women have been physically abused while pregnant. Apart from the risk to the pregnancy, this is regarded as a marker for severe violence and a risk factor for femicide.⁹ Women experiencing combined forms of violence (i.e. physical and mental) have fewer antenatal visits than other women.¹⁰ In Timor-Leste, there does not seem to be a difference between abused and non-abused women in terms of the numbers of live children, but women who experience violence, either physical or combined, are more likely to have a child who has died. In addition, children of abused women are likely to have a lower than average birth weight and are less likely to be fully vaccinated, and so are at a higher risk of mortality.¹¹

The Law on Domestic Violence, enacted in 2009, makes domestic violence a public crime. Socialisation of this law however has not yet been carried out nationwide, and

⁷ Sara Niner, *Hakat Klot, Narrow Steps*, International Feminist Journal of Politics, 13.3 (2011) 413-415

⁸ Angela Taft and Lyndsey Watson, *Violence Against Women in Timor-Leste: Secondary Analysis of the 2009-10 Demographic and Health Survey*, La Trobe University, Melbourne, 2013

⁹ *ibid*

¹⁰ Angela Taft and Lyndsey Watson, *Violence Against Women in Timor-Leste: Secondary Analysis of the 2009-10 Demographic and Health Survey*, La Trobe University, Melbourne, 2013

¹¹ *ibid*

men are not adequately involved in education, awareness raising or changing attitudes on violence against women. Many people are still not aware of the law's provisions, and it will be some time before it is clear whether it reduces violence against women.

A National Action Plan on Gender Based Violence has been developed and its implementation is being coordinated by SEPI. Safe houses exist in six of the 13 districts while four more shelters are planned. Many women who experience violence face impoverishment – as do their children - if their husbands are arrested for assaulting them.

4.4 Disability

In addition to mainstream health services, people with disability require additional services, including rehabilitation and specialised health services. Pregnant women with disabilities are doubly disadvantaged in seeking health services, especially in rural areas.¹² Further investigation is needed on the situation of disabled women in Timor-Leste but international experience shows that pregnant women with a disability may lack confidence in seeking mainstream health services, related to the expectation of encountering discrimination due to perceptions that women with disability should not have children.¹³

4.5 Education

Timor-Leste has achieved gender parity in enrolments in primary and secondary school. Drop-out rates are high for both boys and girls, with only 20 per cent of girls enrolled in high school completing their studies.¹⁴ Female literacy has risen from 43 per cent in 2007 to 70 per cent now but this is still below the 80 per cent literacy rate for males.

Indicators of wasting, immunisation and vitamin A supplementation in children under five are significantly associated with maternal educational levels in analyses that control for the effects of urban/rural location and wealth quintile. Such analyses show no significant association between maternal education and mortality either in this age group or among neonates or infants.¹⁵

4.6 Political life and participation in decision making

Women now hold 38 per cent of the seats in the National Parliament. This means Timor-Leste has achieved the 3rd Millennium Development Goal (MDG) target. However few women are in leadership positions on parliamentary committees.

Timor-Leste lacks a strong women's movement, especially in rural areas, and women lack awareness of their rights, including their reproductive rights. There is little empowerment of women in general (through formal education, community education, participation in politics and community affairs at *suco* and district level) and little encouragement for women to take on leadership roles at village level, although a quota system at *suco* level (see Annex 1) means that they now make up 28 per cent of village councils.¹⁶

¹² Megan McCoy, *Access to Mainstream Health and Rehabilitation Services for People with Disability in Timor-Leste*, AusAID, 2013

¹³ Megan McCoy, *Access to Mainstream Health and Rehabilitation Services for People with Disability in Timor-Leste*, AusAID, 2013

¹⁴ CEDAW, 2009

¹⁵ World Bank, 2012

¹⁶ CEDAW 2009

By participating in decision making at all levels, from the personal to the political, women could increase control over their own health and that of their children. Women's unpaid labour burden, however, limits the degree to which they can participate in public life (70 per cent of all unpaid agricultural labour and 46 per cent of non-agricultural labour is performed by women).¹⁷

Women are also excluded from leadership positions because they are perceived to be shy or to lack adequate education.¹⁸ Women's groups are proliferating but these, and women-only activities, are easily marginalised and risk remaining peripheral to mainstream decision-making bodies and processes.

4.7 Economic empowerment

Poverty is a key gender issue, especially for women in remote or mountainous areas, and for women heads of households, widows and older women. Rural women are particularly vulnerable since 88 per cent of women work in agriculture (as do 82 per cent of men) with poor or uncertain living conditions and with reduced access to services.¹⁹ The patriarchal nature of rural society in Timor-Leste leads to women being disproportionately disadvantaged by rural poverty. Only six per cent of the 442 agricultural extension workers in the country are women. Men also have a greater opportunity to turn crops such as coffee and rice into cash, whereas women tend to grow crops for household consumption.²⁰ Women have less income of their own and less control over family incomes.²¹

Beyond agriculture, the Timor-Leste Strategic Development Plan 2010-2030 promotes development of the service sector as a source of employment opportunities for women, yet in spite of this, girls still have higher levels of unemployment than boys after finishing school, and this inequality may persist even if the service sector expands.²² Only two per cent of women work in the formal sector and are protected by legislation ensuring equal pay and paid maternity leave.²³

The Bolsa da Mae conditional cash transfer programme was initiated in 2008 in all 65 sub-districts, and helps connect vulnerable, women-headed households to formal welfare support services.

4.8 Maternal and child health

The social, political and economic barriers to equality described above all affect health-related behaviours and the availability and use of health care services by women and children,²⁴ thereby contributing to a situation whereby more than half of all deaths in Timor-Leste are attributable to conditions that mainly affect children and women of reproductive age. In Timor-Leste, maternal mortality, at 557 per 100 000,

¹⁷ Ministry for Economy and Development, 2008

¹⁸ Anna Trembath, Damian Grenfell and Carmenesa Muniz Moronha, *Impacts of Non-Government Organisation Gender Programming in Local Communities in Timor-Leste*, Melbourne Globalisation Research Institute, RMIT, 2010

¹⁹ CEDAW 2009

²⁰ JICA 2011

²¹ During a previous visit to Timor-Leste conducting consultations on violence against women, the consultant was told that when assistance is sought for small-scale enterprises, 'women get the small things like chickens and men get the big things like cattle. Men can earn 10 times what the women earn.'

²² UNICEF *At a Glance – Timor Leste*

²³ International Finance Committee, 2010

²⁴ World Bank, 2012

is the highest in the South-East Asia region and is the main driver of gender inequality in mortality in the age group 15-49 years.²⁵

Owing in part to high unmet needs for family planning, the total fertility rate for Timor-Leste is 5.7 births per woman, which is the highest in the South East Asia region.²⁶ In addition, although 80 per cent of women receive some antenatal care, only 30 per cent of births are attended by a skilled provider and only 32 per cent of new mothers and babies receive any postnatal care.

In recent years under-five mortality decreased from 83 to 64 per 1000 live births but there has been no change in neonatal mortality,²⁷ which is affected mainly by care at and around the time of birth and therefore closely linked to maternal health

For a full description of maternal and child health see Annex 2. The ways in which gender inequality affects the health of women and children are also considered in detail in Section 5.

4.9 Nutritional status

The proportion of women who are thin decreased from 38 per cent in 2003 to 27 per cent in 2009-10,²⁸ but malnutrition nonetheless remains a major public health problem, leading to higher risks of illness and death. Overall, 15 per cent of women are of short stature, and therefore at risk for obstructed labour. Women in rural areas are shorter on average than women in urban areas, with 17 per cent falling below the 145 cm cut-off specified by WHO.

Malnourished women are also more likely to give birth to babies of low birth weight who are then likely to face more health challenges than babies of average birth weight. Fifty-eight per cent of children are stunted, but very few women or children are overweight or obese.²⁹

5. Gender issues in the health sector and their implications for program outcomes

Based on the situational analysis above, this section identifies additional gender equality issues specific to the health sector and the main barriers that might prevent women from participating in and benefiting from RMNCH services and/or related community activities.

The DFAT Timor-Leste Health Delivery Strategy considers that the fitness of Timor-Leste's health system to deliver a high-quality continuum of RMNCH care is undermined on both the demand and supply side by major weaknesses in each of the health system building blocks. Document review and discussions as part of this gender analysis confirm those weaknesses, and highlight some additional issues.

Key constraints are listed below in relation to the seven health system building blocks. Some issues straddle more than one building block or involve sectors other than health, with gender equality concerns cutting across all areas.

²⁵ DHS 2009-10

²⁶ Timor-Leste Demographic and Health Survey, 2009-10

²⁷ Timor-Leste Demographic and Health Survey, 2009-10

²⁸ Information on the nutrition situation for men was not available for this review.

²⁹ *ibid*

5.1 Health service delivery

Owing to the lack of laboratory facilities, routine blood tests are not done on all pregnant women to check for iron deficiency, sexually transmitted infections and twins. Blood transfusions are often not available for obstetric emergencies since the only blood bank is in Dili and district hospitals lack systems for identifying compatible donors for all pregnant women. Ensuring sustained delivery of transfusion services and expanding routine blood testing for pregnant women will involve strengthening human resources and infrastructure, supplies, equipment and transport.

Because the majority of births occur at home and are unattended by health professionals, few mothers and babies receive appropriate care at delivery or timely postnatal care that could reduce their risk of dying.

5.2 Infrastructure, supplies, equipment and transport

Health sector vehicle management is unsystematic, and a high proportion of ambulances and multi-function vehicles are not roadworthy owing to lack of maintenance. Fuel supplies for vehicles are also unreliable. Most midwives and nurses lack driving or motorbike riding skills. As a result, ambulance services are often unavailable for obstetric emergencies, emergency obstetric and neonatal care is impeded, and mobile clinics for mothers and children in villages and hamlets are constrained. Even with a reliable fleet of vehicles, however, health workers may not be able to assist with obstetric emergencies in remote rural areas where telephone coverage is limited and poorly maintained roads are impassable in the wet season.

Stockouts of contraceptives leave women at risk of unwanted pregnancies. In addition, some hospitals lack essentials such as anaesthetic, fuel for generators or blood transfusion equipment, and so cannot provide comprehensive emergency obstetric care.

5.3 Health workers

The MoH has no gender equality policy or gender training program for all staff (administrative, medical and technical). There is little evidence that SEPI is consulted.

Among doctors there is an almost exactly 50:50 ratio of men to women. All midwives are women but only about one-third of nurses are female. In the technical/laboratory positions, the qualified technicians are nearly all men, while women predominate in technical/laboratory assistant positions.

There is an overall shortage of midwives. Production and therefore recruitment are constrained by the capacity of the national university, with only a few being recruited from Indonesia. No attempts are made to attract and retrain those who have stopped practicing (because they married, etc) back into the workforce. Cuban trained doctors, who account for the bulk of doctors in rural areas, and most nurses, have no training in obstetrics. Midwives lack training in emergency obstetrics, and many do not attend the 80 deliveries per year required to maintain their competency.

Obstetric training for midwives and nurses does not include some practices that might help prevent emergencies, such as uterine massage to assist the uterus to retract following birth and thus prevent haemorrhaging and the need for blood transfusions.³⁰ Some hospitals lack staff trained to perform blood transfusions.

³⁰ G.J. Hofmeyr, H. Abdel-aleema and M.A. Abdul-Aleema, *Uterine massage for preventing post-partum haemorrhage (Review)*, *The Cochrane Collaborative*, Wiley Press, 2008

In addition, midwives are not always trusted by the women in the communities they are assigned to serve. Women may be reluctant to seek medical attention in an emergency for fear, or perhaps resentment, of being reprimanded by the midwife for not presenting earlier or for not attending regular antenatal care. This may be part of a vicious circle in which community members blame negative outcomes on health workers, who in turn blame users for failing to appreciate the importance of prevention and early intervention. In any case the attitude or 'character' of some midwives is clearly a deterrent to some women seeking medical attention.

Many midwives and single female doctors are reluctant to live alone in what they feel is inappropriate or unsafe accommodation, particularly in remote areas. For doctors who are married couples (including a number of the Cuban trained doctors) often only single accommodation is available.

In addition, integration of the continuum of care is jeopardised by poor cooperation and coordination between PSFs (community volunteers) and MoH staff.

5.4 Health financing

The MoH does not seem to have responded to SEPI's instructions on Gender Responsive Budgeting (see Annex 1). Because MoH budgets are not needs-based, insufficient funds may be allocated for some goods and services that are vital to maternal health, such as contraceptives, blood transfusion and prenatal blood tests.

Many poor families are unable to bear the cost of transport to a health facility. Even more daunting for them is the high cost (sometimes as much as several hundred dollars) of arranging for the return of a body following the death of a patient. Women may therefore be reluctant to go to hospital for fear they will die there and burden their family with the cost of transporting a body home.

5.5 Health information

Health information is vital to understanding health service coverage and facilitating better planning to improve access and utilisation. Timor-Leste's routine health management information system (HMIS) is complicated and collects a lot of data, but MoH does not seem to make good use of it to improve services for mothers and children. Because most HMIS data is not sex-disaggregated, it is difficult to track trends in gender inequality in health. There are also no systems for tracking the use of ambulances and multi-purpose vehicles, so the effect of transport (or lack thereof) on maternal health therefore cannot be monitored.

The quality of the Family Registration System (RSF) is unknown and there is as yet little indication that communities use it to identify local maternal and child health priorities. It is therefore possible that potential entry points for advocacy and mobilisation at community level are being missed.

5.6 Leadership and governance

Although the National Health Sector Strategic Plan includes establishment of health councils, it seems that little thought has yet been given to specific mechanisms to foster women citizens' participation in health sector governance.

At the ministry level, with the exception of the two Vice-Ministers for Health, who are both women, there are few women in positions of authority. The Permanent Secretary of the MoH is male, only two of the 10 Directors or Heads of Departments are women and only two of the 13 District Directors are women. Of the 19 people on the previous GoTL Health Strategy Planning Group, only four were women. No

information was available on the gender balance in the Planning Group for the current Strategy.

5.7 Community mobilisation

Conservative attitudes toward sexuality and reproduction limit adolescents' access to information on sexuality, contraception and the consequences of early pregnancy.

Community level behaviour change communication is hampered by low motivation and high turnover of community health volunteers (PSF), so there are weak links in the continuum of care. Some women and men therefore lack knowledge of family planning and of the need for antenatal, obstetric and postnatal care.

Many mothers lack knowledge of nutrition, including the use of indigenous foods, particularly those that could be used during the 'hunger months'. The weeks following birth are still dominated by 'traditional' beliefs and practices that can increase the risk of infection and undermine optimal breastfeeding. The Alola Foundation seems to be effective in helping mothers change these behaviours, but owing to limited capacity it reaches only a limited proportion of communities.

The Rural Water and Sanitation Program (BESIK) provides a good example of community cooperation that could serve as a model for the health sector. BESIK has succeeded in building capacity of government and partner staff on gender and social inclusion, and in formalising strategies for promoting gender equality and social inclusion in government systems.³¹

A number of NGOs and Church organisations (such as Pastoral Crienca) run community oriented safe motherhood programs, but many of them are struggling to find funds to continue to provide services.

5.8 Multi-sectoral dynamics

As explained in Section 4, gender inequality in health outcomes is affected by factors beyond as well as within the health sector. For example, higher yielding crops could mean longer working hours for women if time needed for weeding, harvesting and processing increases in proportion to production; this could have negative impacts not only on women's own health (especially during pregnancy) but also on the time available to them to feed and care for their children. Robust coordination between sectors is therefore vital.

A recent GoTL initiative aims to strengthen inter-sectoral coordination by grouping related sectors within a Development Policy Coordination Mechanism (DPCM).³² Coordination between MoH and other relevant ministries – especially Social Solidarity, Infrastructure, Public Works, Agriculture, Rural Development and Justice

³¹ Women's representation on Water Management Groups (GMF) has increased from almost nothing to one third. The percentage of women GMF members in technical and management roles has risen from very low to 52% in Community Action Planning (CAP) sites. Women's involvement in key CAP processes (design and implementation planning, community engagement working groups and physical construction) has increased to 35%. Women's involvement in CAP for Sanitation and Hygiene (PAKSI) is almost 40% in participating districts, with a small percentage of women taking up "Natural Leader" roles (which otherwise tend automatically to be filled by the Chef de Suco). Women have strengthened their technical capacity through increased involvement in basic repairs, which is expected to enhance their status and influence in decision-making.

³² Under DPCM the MOH, the Ministry of Education and the Ministry of Social Solidarity make up the Social Sector. Australia provides administrative support to the Social Sector.

(which is responsible for Police Vulnerable Persons Units (VPUs) and management of refugees and safe houses) - is, however, insufficient to take advantage of the potential synergy between the various programs that contribute to good health of women and children, such as clean water, sanitation, hygiene, nutrition, good roads, reduced gender based violence, and support and justice for victims.

6. Recommendations

In keeping with the principles of the New Deal endorsed by the g7+, the program design is a highly flexible one based on ongoing partnership dialogue, learning by doing, and incremental improvement - rather than a sector wide approach or a traditional project. As mentioned in Section 3, this affects the nature of the recommendations of this gender analysis.

Recommendations are therefore grouped under three headings: 'First tier' recommendations are those that can and should be implemented immediately and/or throughout the lifetime of the program. 'Second tier' recommendations are more provisional, since they relate to specific health system building blocks that the partners may or may not decide to prioritise. The final recommendation relates to alignment of the health program with the EVAW program.

6.1 'First tier' recommendations

Recommendation 1: Prioritise package cycles that address women's needs

Dialogue between program partners could influence the choice and sequencing of package cycles; it could also help to ensure that the incentives determined by decision-makers in the first part of the cycle will motivate women as well as men to participate as both users and 'implementers' in the second part of the cycle (in which bottlenecks are resolved). The impact of dialogue between partners will inevitably be incremental.

In choosing package cycles, decision-makers' attention should be drawn to initiatives that could help reduce maternal deaths and/or overcome gender-based barriers to care-giving and care-seeking.

Recommendation 2: Implement package cycles inclusively and consider gender in M&E

Pending the possible development of a gender strategy for the health sector (see Recommendation 4), health sector partners including Australia could advocate and provide technical support for measures to explore and address gender concerns in the implementation and M&E activities for each package cycle that is undertaken. In addition to monitoring whether incentives for women's participation in implementation have the intended effect (see Recommendation 1), such measures could include: suggesting evaluation questions that deal with gender, encouraging disaggregation of quantitative M&E data by sex wherever possible, and supporting qualitative studies to assess gender-specific perceptions of progress toward agreed objectives for each package cycle.

For each package cycle, program partners should undertake dialogue, and agree technical support as needed, to foster (i) gender balance in implementation and (ii) assessment of gender-specific effects as part of M&E.

Recommendation 3: Monitor gender aspects of the transport package cycle

Program partners have decided that the first package cycle will aim to improve health transport. Even if vehicles are roadworthy and efficiently managed, however, gender-related factors could nonetheless affect access to and use of health transport.

This can be explored by monitoring vehicle availability and use by women, children and men. In particular, it will be important to monitor what happens to women experiencing obstetric emergencies who do not make use of available vehicles, and to find out why they do not use them (e.g. cost, the state of the roads, or reluctance to go to hospital). It may be possible to use the RSF as the starting point for this.

Monitoring use of vehicles by midwives could show whether they have access to vehicles when they need them to attend home births. By tracking the use of multi-function vehicles for mobile clinics and correlating this with coverage of mobile clinic services among women and children, the monitoring system can help to demonstrate a causal link between intervention and end of program outcomes.

Comprehensive monitoring is vital, not just to assess whether women use health transport but also to find out whether any of the interventions are perceived negatively by others in ways that could create a backlash and further entrench discrimination.

In addition to enhancing the impact of the first project cycle, the use of such a monitoring system could function as a pathfinder for gender in subsequent cycles, by demonstrating the importance of understanding and addressing gender concerns.

Health sector partners should support the collection and analysis of quantitative and qualitative data to monitor availability and use of MoH vehicles by women, children and men as part of the transport package cycle. Program partners should draw on gender-related learning from this cycle in prioritising and implementing subsequent cycles.

6.2 'Second tier' recommendations

Note that all of the recommendations in this section are contingent on joint decisions by program partners to prioritise particular package cycles to address the relevant challenges.

Recommendation 4: Gender strategy

If the program partners decide jointly to give priority to strengthening the MoH's strategic approach to gender equality as part of one of the package cycles, program partners should consider providing technical support for this in a way that helps the MoH to implement its own plans, as spelt out in DFAT's Guidelines on Integrating Gender Equality in Investment Development.

A gender strategy for the health sector would deal with building MoH capacity for gender analysis and planning, bringing gender into the mainstream of MoH management, training all staff in gender awareness, promoting the use of sex-disaggregated data, and establishing mechanisms for accountability. By identifying institutional arrangements and formalising structures and processes for integrating gender equality, such a strategy would promote the inclusion of gender equality in all policy development, budgetary provisions and implementation, emphasising that gender equality is a core responsibility of MoH and its implementing partners. Thus the strategy would ultimately address the gender dimensions of all elements of the health system.

While the MoH would be the primary focus of such a strategy, it will also need to link with programs in other sectors that affect maternal and child health. Local expertise should be used as much as possible in the development and implementation of the strategy. In addition to multilateral bodies such as UN Women, there is a great deal of expertise and knowledge of gender equality amongst national women's organisations and individuals on which to draw.

If MoH gives priority to developing a full gender strategy for the sector: **health sector partners should be prepared to provide strong support for development of a health sector gender strategy by enlisting both national and international sources of expertise to work under MoH leadership.**

Recommendation 5: Service delivery

A key challenge to improving maternal health and reducing gender inequality in adult mortality is providing blood transfusions for women who experience haemorrhage. If program partners decide to undertake a package cycle to address this they could:

Test ways to strengthen the blood banking service, provide transfusion equipment, develop relevant staff skills, and identify suitable blood donors for all pregnant women.

Recommendation 6: Health workers

In addition to gender awareness training for all staff (see Recommendation 4), interventions related to key cadres could further the objectives of the program. A package cycle devoted to health workers is under consideration; in the event that this cycle is given priority, interventions related to improving the skills, deployment and/or performance of key cadres could be included.

In addition to training to strengthen technical skills in obstetrics, key cadres could be trained in inter-personal skills to foster women's trust in them and willingness to use their services.

If sufficient candidates for midwifery training are likely to be available, the program could consider a scheme to involve villagers in selecting candidates for training from their own villages, where people know and trust them. After completing their training, these midwives would then be assigned to their home villages, where women would then be much more likely to seek their help. This in turn would help midwives to conduct enough deliveries to maintain their competency. Moreover, placing midwives in their own areas would also help to solve the practical issue of their accommodation, particularly in remote areas.

If a package cycle on health workers is undertaken the program partners could:

(a) Continue to work with sector partners to train doctors, nurses and midwives in obstetrics, including preventing and dealing with obstetric emergencies;

(b) Test options for helping relevant cadres deal compassionately and non-judgementally with women's reproductive and maternal health needs;

(c) Consider testing a scheme to involve villagers in selecting candidates for midwifery training from their own villages and assigning the midwives to their home villages once they are qualified.

Recommendation 7: Health financing

To facilitate MoH compliance with requirements for gender responsive budgeting in line with national commitments to reduce gender inequality, the health program could convene and facilitate joint working between MoH and SEPI to develop understanding of SEPI's requirements on Gender Responsive Budgeting and capacity to comply with them in the annual budgetary processes.

If program partners agree to prioritise a package cycle focusing on health financing, the second step of the cycle could:

Include workshops involving MoH, the Ministry of Finance and SEPI to explore ways to orient MoH workplans and budgets to improving availability of appropriate health services and access to them by all women regardless of geographical location, economic circumstances or physical ability.

Recommendation 8: Health information

In addition to using sex-disaggregated data whenever possible in the monitoring and evaluation of each package cycle (see Recommendation 2), strengthening health information in and of itself could become the focus of a future package cycle. In the event that the program partners jointly decide to undertake such a cycle, they could:

(a) Promote disaggregation of key data from HMIS and special surveys by sex, age and disability, and analysis of such data to inform more equitable policy and planning;

(b) Explore the introduction of maternal death audits to improve understanding of determinants of maternal mortality and strengthen the health system's response to them.

Recommendation 9: Leadership and governance; community mobilisation

Raising the status of women through education, facilitating their participation in governance and encouraging them into leadership positions at all levels will help empower women and their communities to make the best decisions about their own health and to demand both high quality services and full access to them.

If the program partners jointly decide to undertake a package cycle focusing on community mobilisation:

(a) Learning from BESIK would be an excellent starting point for testing interventions to build leadership skills among women so that they can influence community activities to identify and address their own health priorities;

(b) Civil society organisations (CSOs) engaged to facilitate community mobilisation should have - or be helped to develop – strong gender skills.

Recommendation 10: Multi-sectoral working

Cross-sectoral concerns may or may not become the focus of package cycles. If they do not, Australia can nonetheless continue to share lessons on gender internally and advocate multi-sectoral efforts to improve gender equality through the DPCM.

If the health program partners give priority to joint work with the Agriculture sector, Australia– as an important partner in both sectors – could:

(a) Facilitate continued joint monitoring of the implications of new crop varieties for women's workloads and health, with a view to encouraging continued development of varieties for which harvesting and processing are less labour-intensive;

(b) Help the ministries work together to promote knowledge of the nutritional benefits of various foods for women and children and the importance of food hygiene.

Recommendation 11: Women with disabilities

Health sector interventions could be better tailored to the needs of women with disabilities if the needs of these women were better understood. In joint dialogue on selecting priority package cycles, Australia can demonstrate its corporate commitments on gender and disability by encouraging MoH to give higher priority to the challenges faced by disabled women. Assuming MoH responds positively:

(a) Australia could commission analytical work to find out more about the needs of disabled women and their children in Timor-Leste after agreeing the scope of the analysis with the MoH;

(b) Program partners should test ways to meet these needs, e.g. by modifying infrastructure, equipment and/or training to make services more appropriate and accessible. If in due course specific training is to be institutionalised, it should be incorporated into established curricula rather than run as stand-alone in-service training.

6.3 Aligning the program to gender-related concerns in the Country Situational Analysis and the Ending Violence Against Women (EVAW) program

At this stage there is no current Country Situational Analysis available for the Australia Timor-Leste Program. The Situational Analysis set out above (and detailed in Annexes 1 and 2) should be the starting point for a gender chapter in the Country Situational Analysis.

Because of the health implications that violence against women has for them and their children, there are strong links between the new EVAW program and the health program and there are a number of areas where the two should closely coordinate so that the two programs complement each other and optimise their outcomes:

- Coordination and collaboration with SEPI who are responsible for coordinating the implementation of the National Action Plan on Gender Based Violence.
- In-referral networks. Referral processes for violence against women within the broader health care system are important since women experiencing violence are more likely to interact with health care providers.
- Collaboration between the programs on behaviour change programs, including those that involve men.
- Collaboration on new research on needs of women experiencing violence, including those with disability.
- Since the health sector has responsibility for managing the safe houses in the hospital grounds, and as community health programs roll out, the role of

these in informing and educating people about problems associated with domestic violence and services that can be offered to survivors will need to be considered.

- The health sector should consider supporting specific campaigns to ensure that abused women have access to health centres and crisis centres.
- If the health program has an element of grant funding for CSOs, this should be coordinated with the EVAW program, with shared analysis and agreement on overlapping objectives and on funding levels.

Recommendation 12: Coordination with the EVAW program

Australia should - as far as possible within the ways of working agreed for the health program - promote close alignment of health program activities and M&E with those of the EVAW program. Wherever possible, existing government information systems to track access to appropriate health services by women experiencing violence and the effectiveness of the health system in meeting their needs should be used.

7. Conclusion

The overall goal of the health program is to reduce maternal and child mortality. Gender equality and recognition of women's rights are vital to achieving this goal.

This program is designed to increase the efficiency of the supply side as well as to foster social transformation on the demand side. The intention to begin with a package cycle addressing the fundamental issue of reliable health transport is appropriate for achieving program outcomes and has the potential to improve gender equality in health. However, many of the factors that prevent women from seeking or obtaining health services and adopting behaviours more conducive to their own health and the health of their children are social, cultural and political; in other words, they stem from the demand side rather than the supply side.

Meeting women's 'strategic needs' will require changes that go beyond the health sector, including: individual and community attitudes; adherence to traditional beliefs and practices; women's roles and status; and their participation in decision making at all levels. For each package cycle in the health program, detailed analysis will be needed in order to fully understand obstacles and opportunities and generate possible responses for iterative testing. Monitoring of impact will also be crucial to find out what is and isn't effective in overcoming gender-related barriers - and ultimately improving the health of Timorese women and their children.

Annex 1: Institutional context

Timor-Leste has made serious efforts to mainstream gender in peacekeeping and the transitional administration, though in this it was somewhat thwarted by insufficient funds. Following lobbying by Timorese women activists, the UN Transitional Authority in East Timor (UNTAET) eventually established a Gender Affairs Unit (GAU) in April 2000. Its mandate was to mainstream gender throughout all functional areas of UNTAET and to ensure the full participation of Timorese women and men in decision-making and as beneficiaries of development including access to resources. Early on, the Unit developed a strong partnership with the Timor-Leste's Women's Network (REDE FETO) (an umbrella organisation uniting 15 women's groups) to promote the Beijing Platform for Action, in particular for a quota of 30% women in all government bodies and the public service.

The GAU's core functions were capacity building and awareness raising, gender data collection and analysis, legislative and policy analysis, networking and outreach. Timorese women were recruited for training in preparation for UNTAET's ultimate withdrawal.

Following independence in 2002, the Office for the Promotion of Equality (OPE) was established within the Prime Minister's Office, to advise on mainstreaming gender throughout the bureaucracy. In 2008, OPE was replaced by the more substantial Secretary of State for the Promotion of Equality (SEPI) with responsibility for creating, coordinating and assessing gender equality promotion policies as defined by the Timor-Leste Council of Ministers.

SEPI is not an implementing agency. Its main functions are coordination and oversight and it serves as the prime mover for gender equality within government. It advocates for the incorporation of gender into all policies, programmes and budgets of government institutions. It also works to reinforce gender mainstreaming in government institutions and state agencies, to raise awareness of gender equality among stakeholders and the general public and to advance women's economic empowerment through public transfers to women's groups.

SEPI established a Gender Focal Point (GFP) network in each ministry and in the districts. The mechanism was successful in that it supported some ministries to conduct gender assessments of their activities, elaborate gender strategies or policies and run internal gender trainings. In the Ministries of Health, Agriculture, Justice, Social Solidarity, Education and Infrastructure and Secretary of State for Training and Employment the GFPs were able to influence the policies of their ministries.

However, the GFPs faced a number of challenges including lack of support from the ministries or secretaries of state, lack of experience and training on gender issues themselves and, crucially, an inability to influence planning or budgeting processes due to their lack of involvement in the planning stage of government activities and in budget setting. Consequently, after three years, the GFP system was replaced with the Gender Working Group (GWG) mechanism, which aims to make coordination more effective, provide easier monitoring and better promote gender mainstreaming by integrating higher level personnel with greater influence into the group.

At the national level GWGs are to be chaired by a Director-General and have Director-level members from, at minimum, all the directorates responsible for Planning, Policy, Finance and Monitoring and Evaluation. At this level, the GWGs are responsible for developing, implementing and monitoring Gender Mainstreaming Work Plans for the entire Ministry and/or Secretary of State. So far, 15 GWGs have been established.

As part of the Government's commitment to introduce Gender Responsive Budgeting (GRB) to ensure that the budget system works for women as well as for men, the National Parliament has now adopted a resolution that gives legal effect to GRB at the national level. The aim is for greater efficiency of public spending, the promotion of equal opportunities and participation of women in decision-making and a more equal distribution of financial burdens and benefits among all citizens. **NOTE:** Despite instructions in Budget Preparation Circulars in 2013 to follow guidelines on GRB, it's not clear whether ministries followed these instructions – or in the 2014 budget. The budget papers are not in English so I need some translations in order to be able to tell.)

The GWGs also contributed to the current combined second and third CEDAW periodic report. A comprehensive questionnaire was sent to the Chairs of the GWG. SEPI received responses from 12 ministries. **Unfortunately, the Ministry of Health was not one of them.**

Timor Leste commitments to gender equality

There are a number of provisions on gender equality in the Timor-Leste Constitution. Section 17, on Equality between women and men gives women and men *'the same rights and duties in all areas of family, political, economic, social and cultural life'*.

Section 63, on Participation by citizens in political life, says *'Direct and active participation by men and women in political life is a requirement of, and a fundamental instrument for consolidating, the democratic system. The law shall promote equality in the exercise of civil and political rights and non-discrimination on the basis of gender for access to political positions.'*

Section 39 states that *'Maternity shall be dignified and protected, and special protection shall be guaranteed to all women during pregnancy and after delivery and working women shall have the right to be exempted from the workplace for an adequate period before and after delivery, without loss of remuneration or any other benefits, in accordance with the law.'*

In 2002, the Government signed and ratified the following international treaties, which indirectly support the promotion of gender equality:

- Convention on the Elimination of all Forms of Racial Discrimination (1965)
- International Covenant on Civil and Political Rights (1966)
- International Covenant on Economic, Social and Cultural Rights (1966)
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1979)
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984)
- Convention on the Rights of the Child (1989), and
- Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women (2000)

The principle of equality is also reflected in the Law against Domestic Violence, the Labour Code and the Electoral Law. In 2004, the Government adopted a strategy for affirmative action and defined set targets for women's representation in Parliament – for every four candidates there was to be one woman. This quota was later raised to one women for every three candidates. Representation on Village Councils is guaranteed by the law on *Suco* elections.

Timor-Leste's strategy of decentralisation is intended to accelerate sustainable economic growth and equitable development from national level to *suco* level, with villages and communities directly involved in planning, constructing and managing their own infrastructure. The Decree-Law has provisioned that out of three representatives from among the members of *Suco* Council representing for Sub-district Development Commissions, at least one must be female.³³

The GoTL displays a commitment to promoting gender equality in its Strategic Development Plan 2011-2030 which states that "Our vision is that in 2030 Timor-Leste will be a gender-fair society where human dignity and women's rights are valued, protected and promoted by our laws and culture. To achieve this vision, we will promote gender mainstreaming across government policies, programmes, processes and budget."

³³ CEDAW 2009

Annex 2: Maternal health

More than half of all deaths in Timor-Leste are attributable to conditions that mainly affect children and women of reproductive age. In Timor-Leste, maternal mortality at 557 per 100,000 is the highest in the South-East Asia region and is the main driver of gender inequality in the age group 15-49 years.³⁴ There are strong socio-economic inequities (related to education, rural location and wealth quintile) in coverage of maternal health care.³⁵

The total fertility rate for Timor-Leste is 5.7 births per woman and is the highest in the South East Asia and Asia region.

The main concern is lack of postnatal care (80 per cent of women receive antenatal care but only 32 per cent receive postnatal care).

It is estimated that the population will increase from its current size of 1.2 million to 1.9 million by the year 2025 and to 3.2 million by 2050. Fertility is considerably higher in rural than in urban areas. The rural-urban difference in fertility is most pronounced for women aged 20-24 (236 birth per 1,000 women in rural areas compared with 187 births per 1,000 women in urban areas). The level of fertility is inversely related to women's educational attainment, decreasing rapidly from 6.1 births among with no education to 2.9 births among women with more than secondary education. Fertility is also inversely associated with wealth quintile with women in the lowest wealth quintile having an average of 7.3 births and women in the highest quintile 4.2.³⁶

Currently married women (78 per cent) and currently married men (66 per cent) in Timor-Leste know of at least one modern method of family planning. The most widely known method among currently married women are injectables (70 per cent) and the pill (58 per cent). Currently married men are most likely to know of the male condom (54 per cent) and injectables (46 per cent). Twenty-two per cent of currently married women are using a method of family planning (21 per cent a modern method). Only one per cent of women report using a traditional method. Injectables are the most popular modern method and are used by 16 per cent of currently married women. Two per cent of women use the pill and about 1 per cent each use the intrauterine device or implants.

There is a considerable percentage of currently married women who desire to control the time and number of births. Thirty-five per cent would like to wait two or more years before the next birth and 36 per cent do not want to have another child.³⁷

Antenatal care is sought by the great majority of women with 86 per cent receiving such care. The greatest percentage (80 per cent) received care from a nurse or a midwife, 4 per cent from a doctor and less than 2 per cent from an assistant nurse. One per cent sought care from a traditional birth attendant. The percentage is higher in Dili (96 per cent) than in rural areas.

Despite the increasing antenatal care, maternal mortality at 557 is the highest in the South-East Asia region and almost twice the average for developing countries. Maternal deaths account for 42 per cent of all deaths of Timorese women aged 15-49. Causes include haemorrhage, obstructed labour, infections, unsafe abortions

³⁴ DHS 2009-10

³⁵ World Bank 2012

³⁶ DHS 2009-10

³⁷ *ibid*

and hypertensive disorders. Owing to lack of reliable statistics for prior years, it is not clear whether maternal mortality has changed in recent years.

Only 22 per cent of births are delivered in a health facility with 78 per cent delivered at home. Delivery in a health facility is most common among young mothers (25 per cent) mothers of fifth-order births (31 per cent) and mothers who have had at least four antenatal visits (31 per cent). Over half (53 per cent) of the children in urban areas are born in a health facility compared with only 12 per cent in rural areas.

Thirty per cent of births are delivered by a skilled provider (doctor, nurse, assistant nurse or midwife) with a nurse or midwife being the most common provider. Three per cent of deliveries are performed by a doctor and less than 1 per cent by an assistant nurse. Eighteen per cent of deliveries are carried out by traditional birth attendants. Women receive assistance from a relative or some other person for 49 per cent of births while 3 per cent of births take place without any type of assistance.

The majority of women (68 per cent) do not receive a postnatal check. Among those who do, 16 per cent receive it in less than four hours after delivery, 5 per cent within 4 to 23 hours and 3 per cent within the first two days. Seven per cent receive postnatal care 3 to 41 days following delivery.³⁸

Child health

In recent years under-5 mortality category decreased from 83 to 64 per 1,000 live births but there has been no change in the neonatal mortality rate.

Causes of child mortality are malaria, diarrhoea and respiratory infections along with poor quality drinking water, inadequate sanitation and poor nutrition. Routine immunisation coverage remains low with only 53 per cent of children aged 12-23 months fully vaccinated and 23 per cent have received no vaccinations. Seventy-five per cent of deaths amongst children under five occur during the first year of life. Infant mortality is 45 deaths per 1,000 live births and neonatal mortality, which has not changed since 2003, is 22 deaths for 1,000 live births.³⁹

Malnutrition

The proportion of malnourished women decreased from 38 per cent in 2003 to 27 per cent in 2009-10, but malnutrition nonetheless remains a major public health problem. 58 per cent of children are chronically malnourished.

Iron deficiency anaemia is a major threat to both maternal and child health. Vitamin A deficiency is high amongst children, poor breastfeeding practices are widespread and iron supplementation for pregnant and postnatal women is inadequate.

Overall, 15 per cent of women are of short stature, and therefore at risk for obstructed labour. Women in rural areas are much shorter on average than women in urban areas with 17 per cent falling below the 145 cm cutoff.⁴⁰

³⁸ DHS, 2009-10

³⁹ *ibid*

⁴⁰ *ibid*

Annex 3: External influences

Portuguese colonialism was an almost totally masculine affair. The large number of soldiers, priests and administrators who held power were almost entirely male. Even professions in other countries normally dominated by females – teaching and nursing – were predominantly male. Opposition to too much education for women was an important part of Portuguese attitudes to women both at home and even more so in the colonies.⁴¹

FRETILIN (The Revolutionary Front for an Independent East Timor) was the first organisation inside Timor to advocate for the equality of women and men in its policies. A women's organisation – the Popular Organisation of Timorese Women (OPMT) – was mentioned in FRETILIN's founding statutes in 1974. The OPMT established crèches to care for war orphans and feed those displaced by the fighting. The founders of OPMT were also among the first to criticise the traditional arranged marriage, the *balaque*, which was felt by many female Timorese to transform women into an object for sale.⁴²

Ironically, the year of the Indonesian invasion of Timor-Leste, 1975, was also International Women's Year and the first year of the UN Decade for Women.

The Indonesian occupation, as with all situations of war, changed the role of Timorese women. Those who survived inevitably found themselves with new responsibilities due to the absence of husbands, brothers and fathers in the resistance, in the Indonesian military or killed by the occupying army. Many women took over running family farms, or worked in offices to earn income to send to the resistance. Some women joined the armed resistance themselves, or were part of local communities that provided food, clothing and medical supplies or captured weapons from the Indonesians for the Falantil troops.⁴³

Under the Indonesian objective of 'demographic dilution' in Timor-Leste, people from Java and other islands of Indonesia were encouraged to come and settle. At the same time, a family planning program was implemented. There is evidence that women avoided the Government health system for fear of covert contraception and sterilisation.⁴⁴ This was particularly the case if they or their families were suspected of being related to FRETILIN. As a result, many women refused to take contraceptives, malaria and vitamin tablets and avoided vaccination campaigns, leaving themselves and their infants unprotected.⁴⁵

The United Nations Mission in Timor-Leste (UNMIT), which followed on from UNTAET, was an integrated mission with the full complement of development, specialised and humanitarian agencies, many of which had a gender focus. They include the United Nations Development Program (UNDP), the United Nations Fund

⁴¹ C.R. Boxer, *Portuguese Timor: A Rough Island Story 1515-1960*, History Today, Vol.10. No.5, pp.349-355

⁴² Rose 'Muki' Bonaparte, *Women in Timor-Leste: Statement by Popular Organisation of Timorese Women*, 18 September 1975, translated by Ines Rodrigues, Direct Action, 104, 4 March 1976, p.7

⁴³ Irena Cristalis and Catherine Scott, *Independent Women: The Story of Women's Activism in Timor-Leste*, Catholic Institute for International Relations (CIIR), London, 2005

⁴⁴ Emma Franks, *Women and Resistance in Timor-Leste "The Centre as they Say, Knows itself by the Margins"*, Women's Studies International Forum, Vol 19, Nos 1&2, 1996, pp. 155-168

⁴⁵ Miranda Sissons, *From One Day to Another: Violations of Women's Reproductive and Sexual Rights in Timor-Leste*, Timor-Leste Human Rights Centre, Fitzroy, 1997

for Women (UNIFEM) (now UN Women), the United Nations Fund for Population Activities (UNFPA), the World Food Programme (WFP), the United Nations High Commissioner for Refugees (UNHCR), and the United Nations Children's Fund (UNICEF).

UNMIT's mandate included: assisting in further strengthening the national institutional and societal capacity and mechanisms for monitoring, promoting and protecting human rights and for promoting justice and reconciliation, including for women and children; facilitating the provision of relief and recovery assistance and access to Timorese people in need, with a particular focus on the most vulnerable, including internally displaced and women and children; and specifically to mainstream gender perspectives and those of children and youth throughout the Mission's policies, programmes and activities, and, working together with United Nations agencies, funds and programmes, support the development of a national strategy to promote gender equality and empowerment of women.

The UN's success in Timor-Leste has been mixed. Its two main sustained achievements have been the Office of Promotion of Equality (OPE), now SEPI, mainstreaming gender into line ministries and districts and building the capacity of line ministries to incorporate gender perspectives in their annual action plans; and the greatly increased role of women in national politics. However, its influence has been limited in rural areas and the impact of the UN Missions on gender relations has not been seen positively by all Timorese, e.g. some representatives of the Church and some traditional leaders consider that promotion of democratic values by the UN, including equal rights for women, has contributed to the decay of traditional Timorese values and culture and threaten the kinship system. It is questionable how much power SEPI has to enforce gender equality policies or how much ministries comply with their instructions on budgetary processes.

Annex 4: Possible gender equality indicators for investing in people

Below is a menu of possible gender indicators, taken from DFAT tools and guidelines. The sample indicators below are divided in to the macro level indicators which can be adapted to report on the achievement of gender equality objectives and outcomes in country and regional performance frameworks and lower level indicators for either country/regional performance or incentive frameworks, or for M&E frameworks for initiatives. It is not expected that every indicator will be relevant to all country and regional strategies. Selected indicators should be identified in partnership with all key stakeholders, including men and women and aligned with the government's international reporting obligations and existing systems. All data should be disaggregated by sex, in addition to other criteria such as socio-economic group (poverty), ethnicity, age, disability and rural/urban differences.

Macro-level indicators: improved and equitable health outcomes for women, men, girls and boys

Gender equality policy outcome: improved and equitable health outcomes for women, men, girls and boys		
Dimensions	Sample gender equality indicators	Data sources
Access	<ul style="list-style-type: none"> Proportion of contraceptive demand satisfied¹ Contraceptive prevalence rate^{2, 3, 4} Adolescent fertility rate^{1, 2} Maternal mortality ratio^{2, 3, 4} Proportion of births attended by skilled health personnel, by ethnicity, rural/urban areas and ethnicity^{2, 3, 4, 7} Incidence of major diseases, by sex, age, rural/urban area, ethnicity and socio-economic group^{6, 7} Percentage of women and men by age diagnosed with STIs, HIV or TB per 1,000 or 100,000² Prevalence of HIV/AIDS in vulnerable female and male groups, by age (children, sex workers, pregnant women)^{2, 3, 5} Rate of mother-to-child transmission of HIV¹⁷ Under-five and infant mortality rate by sex^{2, 3, 7, 9} Proportion of 1 year-olds immunised against measles, by sex³ 	<ul style="list-style-type: none"> National health statistics and census data
- Health	<ul style="list-style-type: none"> Prevalence of underweight children under 5 years of age, by sex³ Proportion of population below minimum level of dietary energy consumption, by sex, ethnicity, urban/rural area^{3, 6} Life expectancy and mortality by sex and age^{2, 4, 6, 7, 9} Sex ratio at birth¹³ Prevalence and death rate associated with malaria and tuberculosis, by sex, ethnicity and urban/rural area³ Access to clean water and sanitation, by sex^{3, 7} 	

Decision making	<ul style="list-style-type: none"> Percentage of women and men at senior, management and executive levels compared with the total percentage of women and men in the health system National policies and processes in place and implemented to foster women's and men's involvement in health and education planning and budgeting 	<ul style="list-style-type: none"> Ministry of Health
Women's rights	<ul style="list-style-type: none"> Legislative prohibition on expulsion from school due to pregnancy or marriage¹⁹ Legislation to protect women, men, girls and boys from sexual harassment and violence in education and health institutions²⁰ National policies and procedures in place and implemented on sexual harassment and gender-based violence in education and health institutions National policies and programs in place to support pregnant girls and women to continue their education 	<ul style="list-style-type: none"> Legal statutes Ministries of education and health
Gender capacity building	<ul style="list-style-type: none"> National programs to reduce gender stereotypes in school curricula and teaching and learning materials^{2, 4} National policies and programs in place to reduce gender disparities in education and health care at all levels² National gender sensitive policies and programs in place on HIV prevention, treatment and care⁴ National policies and programs in place which address the health and education implications of violence against women and girls 	<ul style="list-style-type: none"> Ministries of education and health

Lower-level indicators: health

Gender equality program outcomes:

- Equitable access by women and men to strengthened health systems that respond to their different needs, especially in sexual and reproductive health
- Health consequences of unequal gender relations are addressed for HIV, other major diseases and pandemics

Dimensions	Sample gender equality results	Sample indicators
Access	<p>Increased use of health services by women, men, boys and girls according to their needs</p> <ul style="list-style-type: none"> - use of services - improved health outcomes 	<ul style="list-style-type: none"> Use of health centres in urban/rural areas by sex, age, ethnicity and socio-economic group⁶ Number of visits to/nights spent in hospital by age, sex, urban/rural area and reason for admission^{6, 7} Proportion of males and females by age, urban/rural location and ethnicity who have received health outreach services in the past 12 months⁶ Patient satisfaction with health services, by sex¹⁰ Health infrastructure provides privacy, particularly for reproductive health needs Percentage of boys and girls immunised against major diseases, by rural/urban location, ethnic and socio-economic

		<p>group^{2, 6, 7}</p> <ul style="list-style-type: none"> ▪ Proportion of the population in malaria-risk areas using effective malaria prevention and treatment, by sex, age, ethnicity and socio-economic group³ ▪ Use of antiretroviral treatment by sex, age, ethnicity and socio-economic group¹² ▪ Proportion of tuberculosis cases detected and cured under DOTS, by sex, age, ethnicity, urban/rural area³ ▪ Percentage of women and men diagnosed with diabetes mellitus, by age² ▪ Percentage of women and men who are obese, by age² ▪ Number of suicides per 1000 population, by sex and age² ▪ Percentage of women and men diagnosed with an STI who complete the prescribed treatment⁷ ▪ Percentage of women's/girls' and men's/boys injuries, by cause of injury⁷
	<p>Increased access by women and girls to reproductive health services and information including family planning</p> <p>- reproductive health</p>	<ul style="list-style-type: none"> ▪ Percentage of women who have access to their chosen method of family planning, by age ▪ Proportion of contraceptive demand satisfied for the female condom ▪ Proportion of women and girls who are familiar with the female condom ▪ Number of maternal deaths and illnesses due to unsafe abortion, by age ▪ Proportion of adolescent girls who have had an abortion⁷ ▪ Number of women who received counselling following sexual violence to address trauma and mitigate long-term consequences, including post-exposure prophylaxis^{14, 15} ▪ Percentage of women over 35 years who have had at least one pap smear⁷ ▪ Percentage of women over 50 years who have had a breast examination by a trained health worker⁷ ▪ Number of women over 35 years diagnosed with cervical cancer and breast cancer per 1,000 women in that age group⁸
	- maternal health	<ul style="list-style-type: none"> ▪ Proportion of women with access to maternity care within one hour walk or travel time⁷ ▪ Proportion of pregnant women who received pre-natal and post-natal care from trained staff, by age^{2,4,7} ▪ Proportion of pregnant women who experience major illness related to pregnancy and childbirth, disaggregated by age, ethnicity, socio-economic group, rural/urban area ▪ Percentage of pregnant women with anaemia⁴ ▪ Percentage of HIV positive pregnant women who complete a course of antiretroviral treatment to prevent mother-child transmission¹²
	<p>Health, HIV, STI and family planning information is appropriately targeted to women, men,</p>	<ul style="list-style-type: none"> ▪ Percentage of women and men by age who have received information on family planning, HIV and STIs ▪ Number of high-risk men and women (sex workers, migrant workers, police, military) who receive training, information or resources on HIV and STI infection and women's rights ▪ Sex education curriculum developed and taught in primary and secondary schools, including education on relationship skills,

	<p>and adolescent boys and girls</p> <ul style="list-style-type: none"> - training and information delivered - changes in knowledge and behaviour - involvement of partners and stakeholders 	<p>gender equality, HIV/AIDS and STIs, and violence against women and girls²</p> <ul style="list-style-type: none"> ▪ Percentage of schools with at least one teacher trained in life-skills education and who taught it in the last year¹² ▪ Number and quality of life-skills education programs and resources specifically targeted at adolescent boys and girls, including those with disabilities ▪ Number/percent of women and men by age with comprehensive and correct knowledge of HIV/AIDS prevention and transmission (eg. who know at least 2 or 3 methods of protection against HIV)^{12, 17} ▪ Percentage of sexually active women and men who report using a condoms with all partners, by age^{2, 17} ▪ Condom use rate of the contraceptive prevalence rate³ ▪ Percentage of condom use by women and men by age at the last incident of high-risk sex (eg. proportion of male and female sex workers who report using a condom with last client)^{3, 17} ▪ Number of men disclosing their HIV status to their partners¹⁶ ▪ Number of non-government and women's organisations providing quality training, information and awareness-raising activities targeted at women, men and adolescent boys and girls ▪ Number and quality of activities undertaken to reduce stigma related to HIV and STIs, and number of males and females participating by age
	<p>Health and HIV communication strategies recognise and respond to women's responsibilities for health care</p>	<ul style="list-style-type: none"> ▪ Programs targeted at men focus on the importance of joint parental and care responsibilities ▪ Health and HIV communication strategies focus on the gender dimensions of health care and of HIV prevention, treatment and care ▪ Specific programs and social protection measures developed that target the needs of care-givers ▪ Number of male and female home-based care-givers and volunteers provided with training, counselling and support^{14, 16}
	<p>Female and male health service professionals available to address women's, girls', men's and boys' different health needs, particularly in rural areas</p>	<ul style="list-style-type: none"> ▪ Proportion of rural and urban health centres with adequate professional male and female staff ▪ Proportion of male and female health staff in rural/urban locations⁶ ▪ Proportion of male and female health staff trained in reproductive health services, HIV/AIDS prevention and treatment and in providing support for survivors of gender-based violence⁹ ▪ The ratio of males and females employed as nurses, paramedics and doctors² ▪ Population per doctor, nurse and paramedic, by sex^{2, 4} ▪ The number of males and females enrolled in training programs for nurses, paramedics and doctors² ▪ Views of patients on the quality of care and availability of staff¹⁰
Decision making	<p>Community participation by women and men in health and HIV</p>	<ul style="list-style-type: none"> ▪ Percentage of women and men in community-based health committees at different levels (national, regional, district, local)⁷ ▪ Type of involvement by women and men in community-based health committees (eg. health education, community-based

	service design, delivery and management	<p>outreach services, health centre boards and management etc)⁷</p> <ul style="list-style-type: none"> ▪ Type and quality of links between community-based health committees and local women's organisations and community groups⁷ ▪ Number of women and men recruited to serve as health volunteers, and the percentage of these who continue as volunteers⁹ ▪ Number of women and men living with HIV/AIDS involved in the planning, design, implementation and evaluation of HIV/AIDS programs
	Changed community attitudes about appropriate roles, knowledge and decision making by women and men relating to health, including sexual and reproductive health	<ul style="list-style-type: none"> ▪ Percentage of women who report that they exercise increased decision-making or control over health, family planning and sexual relations, and the reasons for any change ▪ Percentage of men who report changed attitudes on health, family planning and sexual relations, and the reasons for any change ▪ Percentage of adult men and women who support STI and HIV education programs for adolescent boys and girls¹² ▪ Percentage of family income spent on food and health care ▪ Changes in the percentage of women's and men's income spent on food and health care, and the reasons for any change⁷
	Increased participation by female health professionals in health service management	<ul style="list-style-type: none"> ▪ Proportion of male and female health staff, by level of seniority, rural/urban location and level of service (national, regional, district, local; administration versus health service delivery)^{6, 7} ▪ Percentage of female and male health personnel in managerial and professional posts, compared with the total proportion of male and female staff in the health service⁷ ▪ Percentage of female health personnel who receive training opportunities (overseas, pre-service, in-service), compared with the total proportion of male and female staff in the health service⁷
Women's rights	<p>Increased awareness by women, men, and adolescent boys and girls of:</p> <ul style="list-style-type: none"> - women's health needs, in particular their reproductive needs and rights - the risk factors for contracting STIs 	<ul style="list-style-type: none"> ▪ Health education and outreach materials and initiatives focus on women's right to decision-making regarding sexuality, contraception, child-bearing, nutrition and freedom from violence⁷ ▪ Training and awareness-raising programs in place that focus on men's joint parental responsibilities, and the impact of violence against women and girls, casual sex, multiple partnerships and refusal to use contraceptives ▪ Proportion of adolescent girls and women with accurate knowledge about reproductive health and family planning, by age ▪ Changes in men's use of contraceptives, and their reasons ▪ Changes in men's willingness to use condoms with their wives and girlfriends ▪ Percentage of women and men by age with comprehensive and correct knowledge of HIV/AIDS prevention and transmission³ ▪ Percentage of condom use by women and men by age at the last incident of high-risk sex³ ▪ Percentage of women and men, by age, who understand the links between violence against women and girls and the risk of contracting STIs and HIV

	Women and girls empowered to make informed choices to protect their health and to use services, including contraceptive and other reproductive health services	<ul style="list-style-type: none"> ▪ Removal of legal and regulatory barriers that prevent women and men from accessing the full range of reproductive health services including family planning, contraception and post-exposure prophylaxis following sexual violence^{7, 15} ▪ Health information, education and communication materials reinforce women's rights, including the right to live free from violence ▪ Health and HIV information, education and communication materials show women and men as equal partners in decision-making about health, sexual relations and family planning ▪ Affordable legal services available to protect the legal rights of women and men living with or affected by HIV/AIDS¹⁵ ▪ Public awareness programs in place to eliminate discrimination against women, and stigma against women and men living with HIV/AIDS¹⁵
	Men's participation in advocacy for gender equality and women's rights	<ul style="list-style-type: none"> ▪ Changes in men's perceptions (including young men) about women's sexual and reproductive rights, violence against women and girls and men's responsibilities ▪ Increase in the number of male leaders who advocate for women's sexual and reproductive rights, and men's responsibilities and against gender-based violence ▪ Number of campaigns that actively involve men in communicating the risk factors for HIV, including the impact of violence against women
Gender capacity building	Increased awareness by health providers of the impact of women's and girls' workloads and gender power relations on the risk factors for ill-health, the use of services and the burdens of health care	<ul style="list-style-type: none"> ▪ Health worker training programs include modules that focus on gender differences in health risks through the life cycle, responses to disease, and the use of health services ▪ Health worker training programs include modules on the quality of care (including technical standards, the provision of information and the importance of treating male and female patients with respect) ▪ Number of training sessions undertaken ▪ Number of male and female health workers trained¹⁰ ▪ Percentage of male and female health workers who are able to explain women's and men's common and different health needs, and how change over the life cycle ▪ Level of understanding and acceptance by health staff that gender inequality and gender relations are factors that influence an individual's health⁷
	Increased capacity of national health systems to provide quality family planning and sexual and reproductive health services for women and adolescent girls	<ul style="list-style-type: none"> ▪ Number of primary health care services that provide an integrated approach to reproductive health and counselling, prevention and treatment of HIV and STIs¹¹ ▪ Percentage of health services able to provide obstetric services and percent able to perform caesarians⁷ ▪ Proportion of health workers trained and skilled in providing a range of family planning and contraceptive services⁷ ▪ Number of training sessions undertaken ▪ Knowledge, attitudes and practices of health workers towards reproductive health, family planning and contraceptive services⁷ ▪ Protocols, procedures and service delivery practices are gender-sensitive and promote women's rights (eg. protection of women's right to privacy and confidentiality)^{7,15} ▪ Number of health services/centres that implement appropriate protocols for dealing with cases of gender-based violence

		<ul style="list-style-type: none"> ▪ Number and quality of initiatives which include men in reproductive health initiatives ▪ Number, type and quality of initiatives aimed at increasing women's control over their fertility and sexual health ▪ Percentage of the health budget allocated for family planning and sexual and reproductive health services²
	<p>Increased capacity of national health systems to respond to the different needs, priorities and interests of women, men, boys and girls in health service delivery and in responses to pandemics and other diseases</p> <p>- SWAPs, policies and plans</p> <p>- human resource management and development</p> <p>- resourcing</p> <p>- health information systems</p>	<ul style="list-style-type: none"> ▪ Sector-wide approaches to health include gender analysis and gender equality strategies to address inequities in access to and outcomes from health services ▪ Health sector plans explicitly recognise the different health needs of males and females, including their reproductive health needs and other differences relating to workload, gender roles and power relations and how these differ through the life cycle² ▪ Adoption of a national plan and strategy on HIV/AIDS that includes gender analysis and gender equality strategies (eg. that explicitly acknowledges links between gender-based violence and HIV)^{2,4,15} ▪ National health policy promotes gender equity in access to services, training and employment² ▪ Women's organisations that focus on gender-based violence and women's reproductive rights participate in health service policy development and review ▪ Policies, workforce development plans and incentive strategies are in place to attract and retain trained female health staff in rural and remote areas ▪ Targeted programs and incentives are in place to train and retain female and male health professionals from ethnic minorities ▪ Salary differentials of women and men health workers by level of seniority in the health workforce⁷ ▪ Percentage of government health expenditure devoted to women's health needs (national, urban and rural areas)^{2,6} ▪ Percentage of the health budget allocated for non-curative services (pre-natal care, MCH, immunisation, health education)² ▪ Proportion of funds for medical research that focus on women's health⁴ ▪ Proportion of government health budget allocated to HIV/AIDS prevention, treatment and care ▪ Sex-disaggregated data is routinely collected and reported on the prevention, treatment and cure of major diseases ▪ The impacts of health decentralisation and financing initiatives are monitored, particularly gender differences in the use of health services and health-seeking behaviour for different ethnic and rural/urban communities ▪ The impact of health sector reforms on male and female employment as health workers is monitored⁷ ▪ Data routinely collected on the causal links between HIV and gender-based violence

Annex 5: Methodology

The analysis was conducted through (i) a review of documentation, i.e. health program documentation prepared to date, related program documents, existing research on related national health and gender equality issues, national health strategies and partnerships agreements between Timor-Leste and Australia plus (ii) interviews with key government and UN agency officials and civil society representatives while in Timor-Leste.

Question 1 from the Terms of Reference “*What are the key gender equality issues in health and the main barriers which might prevent women and men from participating in and benefitting from RMNCH services and/or related community activities in Timor-Leste?*” is the key overarching question. The answers to the remaining four questions from the Terms of Reference resulted from the analysis of the information obtained in response to Question 1, i.e. the identification of the challenges, gaps and barriers to the success of the Investment Design. This in turn informed the recommended actions needed to ensure that gender equality is appropriately dealt with in the design.

Given the amount of information already available on mothers’ and children’s health, including violence against women, there was no need to gather further such statistics or to do any further quantitative analysis. Rather a qualitative analysis was carried out of the perceived gender-related obstacles, both technical and cultural, to improving mothers’ and children’s health. It is emphasised that this analysis is an analysis of existing information with no new quantitative research data being gathered.

There is, however, less specific information available in a number of areas that have a bearing on the program design, i.e. human resource statistics, particularly sex-disaggregated data for all health sector staff, formal measures being taken to mainstream gender throughout Ministry of Health and all those where coordination is needed with the Ministry of Health, and resources, including gender responsive budgeting. As far as possible, this additional information was gathered prior to the interviews.

The intention of the interviews was to establish what advances have been made to date in establishing women’s rights and increasing their participation in all levels of decision making, what remains to be done to achieve this and what specific areas need to be concentrated on.

The questions were aimed at establishing what has been done to date to achieve gender equality in Timor-Leste, what priority areas remain to be addressed, how these relate to the health sector, how all relevant areas can work together, and how they can be integrated into the health program design.

Interviews were conducted in English with translators if no English speakers were available. DFAT program staff were responsible for arranging appointments and for providing interpreters as needed.

All information gathered in interviews and through the review of documentation was classified into thematic areas for a descriptive analysis. Recommendations were made on those areas where information appears to be lacking, is incomplete or is contradictory on what is needed to more comprehensively identify those actions needed to ensure gender equality is dealt with thoroughly during program implementation.

Conclusions drawn from observations and opinions gained from interviewees and, where possible, backed up by available data, formed the basis for recommended

actions to be included in the program design. An analytical framework was developed to assess gender mainstreaming nationally and how it integrates in the health sector. This was not a quantitative research exercise involving surveys and targeted questionnaires, nor was it aimed at measuring specific outcomes, attributing cause, classifying and ranking etc. The framework therefore used qualitative methods with categories derived directly from the data, e.g. component/category of analysis/indicators and incorporating ideas generated throughout the process. This framework guided the recommendations for the gender equality actions to be integrated into the health program design.

Key questions

Given that gender equality within the health sector needs to be addressed within the overall context of gender equality in Timor-Leste, the questions listed in the Terms of Reference needed to be informed by a broader range of information. This information was elicited both through the interviews and from existing documentation and falls into the following categories:

- Legislation
- Institutional
- Policy
- Cultural
- Resources
- Human resources
- Socio-political
- Workforce participation
- Education
- Logistics
- Coordination
- Progress to date on achieving gender equality

List of people met

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Takaho Fukami, Chief of Education, UNICEF

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Dr Domingas Bernardo, Assistant Representative, UNFPA

Ms Carla da Costa, Program Analyst, UNFPA

Ms Milena Pires, UN CEDAW Committee
Charlemagne Sophia Gomez, Legal Gender Adviser, National Parliament of Timor-Leste
Nicola Morgan, Country Director, Maries Stopes International, Timor-Leste
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